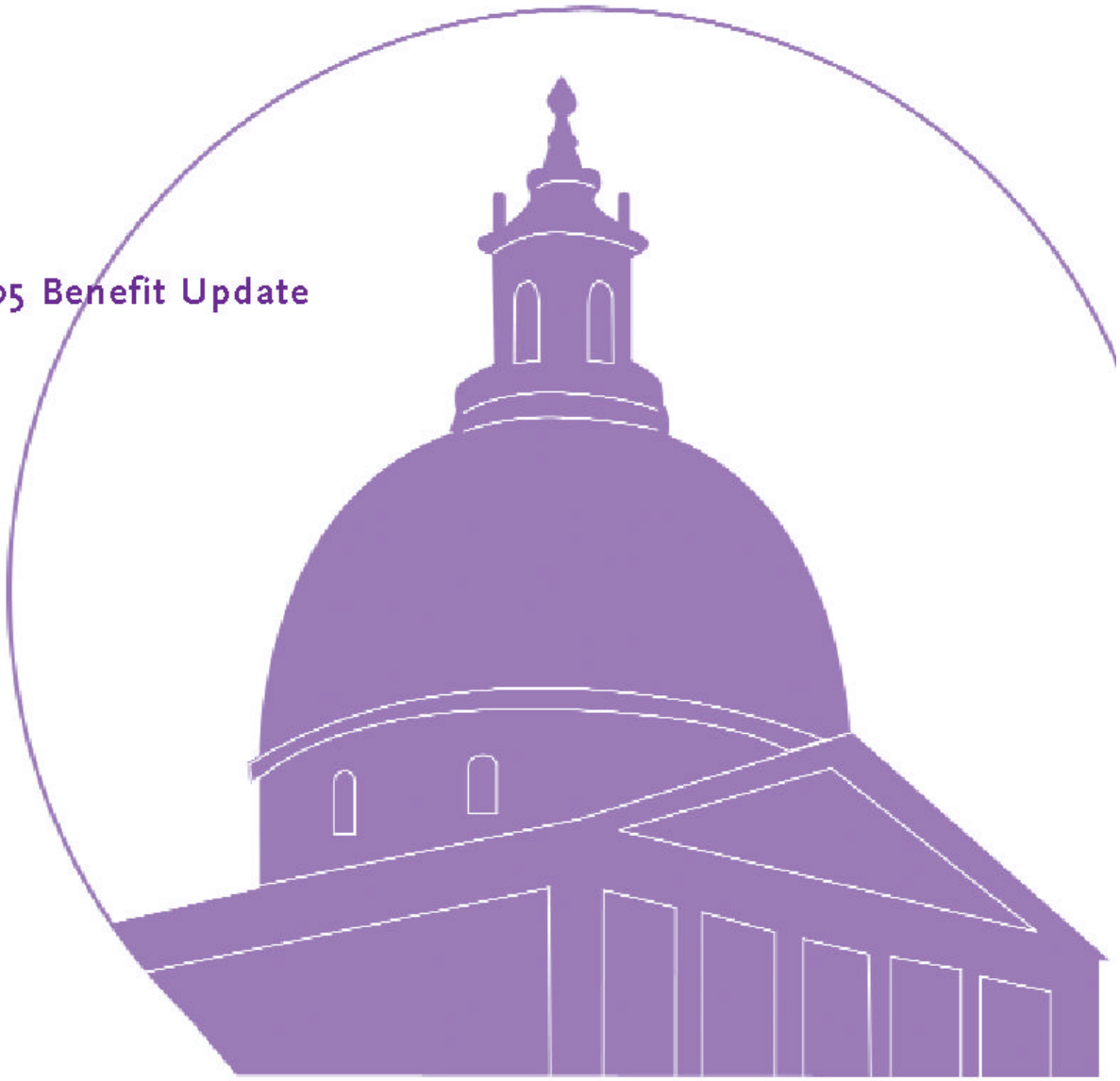
NAVIGATOR

by TUFTS Health Plan

Commonwealth of Massachusetts
Group Insurance Commission



> 2005 Benefit Update

Navigator By Tufts Health Plan Benefit Update (2005) GIC-NAVPPO-AMDMT-001 Ed. 7-2005

The information below amends the language in your 2004 Navigator by Tufts Health Plan™ ("Navigator") *Member Handbook* (7-2004 edition). This Benefit Update describes revised benefits, benefit clarifications, and other important information about your Medical and Prescription Drug Plan under the Navigator Plan administered by Tufts Health Plan ("Tufts HP").

Please note that there are no changes to your EAP/Mental Health and Substance Abuse Plan administered by United Behavioral Health ("UBH").

You should put these pages in your 2004 Navigator *Member Handbook* for easy reference.

MEDICAL AND PRESCRIPTION DRUG PLAN

This section describes benefit clarifications and benefit revisions to your health care coverage under the Navigator Plan. These changes and revisions are effective as of July 1, 2005, unless otherwise indicated below.

Benefit Revisions:

•Navigator Plan *Inpatient Hospital Copayment* Levels

- The "Navigator *Inpatient Hospital* List" found in Part 11 (pages 75-78) of your 2004 Navigator *Member Handbook* has been revised. See pages 4-7 of this Benefit Update for the List in effect as of July 1, 2005.
- Effective July 1, 2005, the following three *Copayment* Levels apply to *Inpatient* admissions at *Tufts HP Hospitals* for *Obstetric Services*, *Pediatric Services*, and *Adult Medical and Surgical Services*:
  - *Copayment* Level 1 - $150 *Copayment* per admission for *Tufts HP Hospitals* with the **best quality-cost scores**.
  - *Copayment* Level 2 - $300 *Copayment* per admission for *Tufts HP Hospitals* with **better quality-cost scores**.
  - *Copayment* Level 3 - $500 *Copayment* per admission for *Tufts HP Hospitals* with **good quality-cost scores**.

  All references in your 2004 Navigator *Member Handbook* to the two *Copayment* Levels for *Inpatient Tufts HP Hospital* admissions (see pages 1, 10, 15, 21, and 75-78) are changed to reflect the new three *Copayment* Levels.

•Special Medical Formulas

Effective July 1, 2005, "Low protein foods" and "Nonprescription enteral formulas" are covered in full at the *Out-of-Network Level of Benefits.* As a result of this change, the "Special Medical Formulas" benefit listed under "Other Health Services" on page 17 of the "Benefit Overview" section in your 2004 Navigator *Member Handbook* is changed to read as follows:

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Special Medical Formulas		
Low protein foods ☞ Page 46	Covered in full. **Covered up to a total of $2,500 per *Member* in a calendar year (In-Network and Out-of-Network Levels combined).**	*Deductible* & 20% of the *Reasonable Charge* (plus any balance).
Nonprescription enteral formulas **(AR)** ☞ Page 47	Covered in full.	Covered in full.
Special medical formulas **(AR)** ☞ Page 47	Covered in full.	Covered in full.

•Prescription Drug Benefit

Effective January 1, 2005, the list of "Non-Covered Drugs with Suggested Alternatives" found in Part 10 (pages 73-74) of your 2004 Navigator *Member Handbook* has been changed to read as follows:

Part 10– Non-Covered Drugs With Suggested Alternatives

This list of non-covered drugs is effective January 1, 2005 and may change during the year. Drugs may be added to this list for safety reasons, when a new drug comes to market, or if a prescription drug becomes available over-the-counter.

IMPORTANT NOTE: Please see the *Tufts Health Plan* Web site at **www.tuftshealthplan.com** for the most current list or call a Member Services Coordinator.

Brand Name	Suggested Alternatives
AcipHex	omeprazole (Tier-1, lowest *Copayment*) or Nexium or Prevacid (Tier-3, highest *Copayment*)
Atacand	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Atacand HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Avalide	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Avapro	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Axid	nizatidine (Tier-1, lowest *Copayment*)
Beconase AQ	Nasacort AQ, Flonase, Nasonex, or Rhinocort Aqua (Tier-2, middle *Copayment*)
Bright Beginnings Prenatal Supplement Bars	prenatal vitamins plus iron (Tier-1, lowest *Copayment*)
Capoten	captopril (Tier-1, lowest *Copayment*)
Clarinex	loratidine and chlorpheniramine (OTC, not covered); Allegra or Zyrtec (Tier-3, highest *Copayment*)
Dynacin	minocycline hcl (Tier-1, lowest *Copayment*)
EC Naprosyn	enteric-coated naproxen (Tier-1, lowest *Copayment*)
Flagyl 375 mg, Flagyl ER	metronidazole tablets 250mg, 500mg (Tier-1, lowest *Copayment*)
Genotropin	Humatrope, Norditropin, Nutropin, Protropin, Saizen (Tier-2, middle *Copayment*)
Klonopin	clonazepam (Tier-1, lowest *Copayment*)
Lidex, Lidex-E	fluocinonide and fluocinonide E (Tier-1, lowest *Copayment*)
Lopressor	metoprolol (Tier-1, lowest *Copayment*)
Lupron 1mg/0.2mL vial and kit	leuprolide 1mg/0.2mL vial and kit (Tier-1, lowest *Copayment*) (prior authorization required for males age 25 and older)
Mevacor	lovastatin (Tier-1, lowest *Copayment*)
Micardis	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Micardis HCT	Diovan HCT and Hyzaar (Tier-3, highest *Copayment*)
Minocin	minocycline hcl (Tier-1, lowest *Copayment*)

(continued on next page)

•Prescription Drug Benefit - continued

Part 10– Non-Covered Drugs With Suggested Alternatives - continued

Brand Name	Suggested Alternatives
Monistat Dual-Pak	miconazole or clotrimazole (OTC, not covered), or Diflucan 150mg (Tier-2, middle *Copayment*) or Terazol 3/7 (Tier-3, highest *Copayment*)
Monodox	doxycyline monohydrate (Tier-1, lowest *Copayment*)
Naprelan	naproxen sodium ext-rel (Tier-1, lowest *Copayment*)
Pepcid (except suspension)	famotidine (Tier-1, lowest *Copayment*)
Prevacid Naprapac	naproxen (Tier-1, lowest Copayment) plus omeprazole (Tier-1, lowest *Copayment*) or Nexium or Prevacid (Tier-3, highest *Copayment*)
Prilosec	omeprazole (Tier-1, lowest *Copayment*) or Nexium and Prevacid (Tier-3, highest *Copayment*) PLEASE NOTE: Prilosec is covered for *Members* 12 years of age and younger (Tier-3, highest *Copayment*)
Prinivil	lisinopril (Tier-1, lowest *Copayment*)
Prinzide	lisinopril/hydrochlorothiazide (Tier-1, lowest *Copayment*)
Relenza	amantadine (Tier-1, lowest *Copayment*)
Reprexain	hydrocodone/ibuprofen or ibuprofen alone (Tier-1, lowest Copayment)
Sporanox (capsules only)	Lamisil tablets (prior authorization required) (Tier-3, highest *Copayment*)
Tamiflu	amantadine (Tier-1, lowest *Copayment*)
Teveten	Benicar, Cozaar, or Diovan (Tier-3, highest *Copayment*)
Teveten HCT	Diovan HCT or Hyzaar (Tier-3, highest *Copayment*)
Valium	dazepam (Tier-1, lowest *Copayment*)
Vasotec	enalapril (Tier-1, lowest *Copayment*)
Vicoprofen	hydrocodone/acetaminophen combination products or ibuprofen alone (Tier-1, lowest *Copayment*)
Xanax/Xanax XR	alprazolam (Tier-1, lowest *Copayment*)
Zocor	Lipitor, Pravachol, or Crestor (Tier-2, middle *Copayment*)

•Navigator Plan *Inpatient Hospital Copayment* Levels

Effective July 1, 2005, the "Navigator *Inpatient Hospital* List" found in Part 11 (pages 75-78) of your 2004 Navigator *Member Handbook* has been revised to read as shown below. In addition, please note that the Navigator Plan *Inpatient Hospital* Copayment Levels are available by calling Member Services or on the *Tufts Health Plan* Web site at **www.tuftshealthplan.com**.

Part 11– Navigator Plan Inpatient Hospital Copayment Levels - continued

Under the Navigator Plan, *Copayments* for *Inpatient* hospital stays at *Tufts HP Hospitals* for *Obstetric Services*, *Pediatric Services*, and *Adult Medical and Surgical Services* are grouped into *Inpatient* Hospital *Copayment* Levels, which are based upon the **quality-cost score** for each of these services. (You can call Member Services for more information about hospital groupings.)

- *Tufts HP Hospitals* with the **best quality-cost scores** are grouped in ***Copayment* Level 1**. *Inpatient Obstetric Services*, *Inpatient Pediatric Services,* and *Adult Medical and Surgical Services* at a *Network Hospital* included in *Copayment* Level 1 are subject to **a $150 *Copayment*** per admission.

- *Tufts HP Hospitals* with **better quality-cost scores** are grouped in ***Copayment* Level 2**. *Inpatient Obstetric Services*, *Inpatient Pediatric Services,* and *Adult Medical and Surgical Services* at a *Network Hospital* included in *Copayment* Level 2 are subject to **a $300 *Copayment*** per admission.

- *Tufts HP Hospitals* with **good quality-cost scores** are grouped in ***Copayment* Level 3**. *Inpatient Obstetric Services*, *Inpatient Pediatric Services,* and *Adult Medical and Surgical Services* at a *Network Hospital* included in *Copayment* Level 3 are subject to **a $500 *Copayment*** per admission.

  Important Note:

  These *Copayment* Levels do not apply to:

  - specialized hospitals (including the Massachusetts Eye and Ear Infirmary, the New England Baptist Hospital, or the Dana Farber Cancer Institute);
  - *Tufts HP Hospitals* with fewer than 100 admissions per year for *Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*; or
  - *Tufts HP Hospitals* located outside of Massachusetts.

  Your *In-Network* care at these *Tufts HP Hospitals* is subject to a $300 *Copayment* per admission.

There are other *In-Network* services for which the *Inpatient* Hospital *Copayment* Levels do not apply. These include:

- Services for newborn *Children* who stay in the hospital beyond the mother's discharge. **These services are covered in full.**
- Covered transplant services for Members at the Plan's In-Network Transplant Centers of Excellence. **These services are subject to a $150 *Copayment* per admission.**

The Navigator *Inpatient* Hospital *Copayment* List, which appears in the following table, lists *Hospitals* and the applicable *Copayments* for *Inpatient Obstetric Services*, *Pediatric Services*, or *Adult Medical and Surgical Services*.

(continued on next page)

•Navigator Plan *Inpatient Hospital Copayment* Levels – continued

Massachusetts

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
East	Addison Gilbert Hospital	$300 (NL*)	$300 (NL*)	$500
	Anna Jaques Hospital	$500	$500	**$150**
	Beth Israel Deaconess Hospital – Needham	$300 (NL*)	$300 (NL*)	$500
	Beth Israel Deaconess Medical Center	$500	$300 (NL*)	$300
	Beverly Hospital	$300	$500	**$150**
	Boston Medical Center	$300	**$150**	**$150**
	Brigham and Women's Hospital	$300	$300 (NL*)	$300
	Brockton Hospital	$300	$300	$300
	Cambridge Hospital	$300	$300	$300
	Cape Cod Hospital	**$150**	$300	**$150**
	Caritas Carney Hospital	$300 (NL*)	$500	$300
	Caritas Good Samaritan Medical Center	$300	$300 (NL*)	**$150**
	Caritas Holy Family Hospital	$300	$300	$500
	Caritas Norwood Hospital	$500	$500	$300
	Caritas St. Elizabeth's Medical Center	$500	$300 (NL*)	$500
	Charlton Memorial Hospital	$300	$300 (NL*)	$300
	Children's Hospital	$300 (NL*)	$300	$300 (NL*)
	Dana-Farber Cancer Institute	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Emerson Hospital	**$150**	$300	$300
	Falmouth Hospital	$500	$500	**$150**
	Faulkner Hospital	$300 (NL*)	$300 (NL*)	**$150**
	Jordan Hospital	**$150**	$300	$300
	Lahey Clinic Hospital	$300 (NL*)	$300 (NL*)	$300
	Lawrence General Hospital	$300	$500	$500
	Lawrence Memorial Hospital (Hallmark Health Systems)	$300 (NL*)	$300 (NL*)	**$150**
	Lowell General Hospital	**$150**	**$150**	$300
	Massachusetts Eye and Ear Infirmary	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Massachusetts General Hospital	$300	$300	$300
	Melrose Wakefield Hospital (Hallmark Health Systems)	**$150**	$300 (NL*)	**$150**
	Merrimack Valley Hospital	$300 (NL*)	$300 (NL*)	$500
	Metrowest Medical Center – Framingham	**$150**	$300	$500
	Metrowest Medical Center- Leonard Morse	$300 (NL*)	$300 (NL*)	$500

NL* These *Hospitals* are not grouped in a *Copayment*/*Coinsurance* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* listed above are in effect as of July 1, 2005. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

(continued on next page)

•Navigator Plan *Inpatient Hospital Copayment* Levels – continued

Massachusetts - continued

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
East, continued	Milton Hospital	$300 (NL*)	$300 (NL*)	$500
	Morton Hospital	**$150**	$300	**$150**
	Mount Auburn Hospital	$300	$300 (NL*)	$300
	New England Baptist Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	New England Medical Center	$500	**$150**	$300
	Newton-Wellesley Hospital	**$150**	**$150**	**$150**
	Quincy Medical Center	$300 (NL*)	$300 (NL*)	$300
	Saints Memorial Medical Center	$500	$300 (NL*)	$300
	Salem Hospital (North Shore Medical Center)	$300	$300	$500
	South Shore Hospital	$300	**$150**	**$150**
	St. Anne's Hospital	$300 (NL*)	$500	$500
	St. Luke's Hospital	$300	**$150**	$300
	Sturdy Memorial Hospital	$500	$300	$500
	Tobey Hospital	$500	$500	$500
	Union Hospital (North Shore Medical Center)	$300 (NL*)	$300 (NL*)	$500
	Winchester Hospital	**$150**	**$150**	**$150**
Central	Athol Memorial Hospital	$300 (NL*)	$300 (NL*)	$500
	Clinton Hospital	$300 (NL*)	$300 (NL*)	$500
	Harrington Hospital	$500	$500	$500
	HealthAlliance Hospitals	$300	$500	$300
	Heywood Hospital	$500	$500	$300
	Hubbard Regional Hospital	$300 (NL*)	$300 (NL*)	$500
	Marlborough Hospital	$300 (NL*)	$300 (NL*)	$300
	Milford-Whitinsville Hospital	$300	**$150**	$300
	Nashoba Valley Medical Center	$300 (NL*)	$300 (NL*)	$300
	St. Vincent Hospital	**$150**	**$150**	**$150**
	UMass Memorial Medical Center	$300	$500	$500

NL* These *Hospitals* are not grouped in a *Copayment/Coinsurance* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* are in effect as of July 1, 2005. For the most up-to-date status, please contact Member Services at 1-800-870-9488.

(continued on next page)

•Navigator Plan *Inpatient Hospital Copayment* Levels – continued

Massachusetts - continued

Region	*Hospital*	*Obstetrical Care Copayment*	*Pediatric Care Copayment*	*Adult Medical/Surgical Care Copayment*
West	Baystate Medical Center	$300	**$150**	**$150**
	Berkshire Medical Center	**$150**	**$150**	**$150**
	Cooley Dickinson Hospital	**$150**	$300	$500
	Fairview Hospital	$500	$300 (NL*)	$300
	Franklin Medical Center	**$150**	$300 (NL*)	$300
	Holyoke Hospital	$500	$300 (NL*)	**$150**
	Mary Lane Hospital	$500	$300 (NL*)	**$150**
	Mercy Medical Center	**$150**	$300 (NL*)	**$150**
	Noble Hospital	$300 (NL*)	$300 (NL*)	$300
	North Adams Regional Hospital	$500	$300	$500
	Wing Memorial Hospital	$300 (NL*)	$300 (NL*)	**$150**

New Hampshire

	Catholic Medical Center	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Elliot Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	HCA Parkland Medical Center	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Mary Hitchcock Memorial	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Southern N.H. Regional Medical Center	$300 (NL*)	$300 (NL*)	$300 (NL*)
	St. Joseph Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)

Rhode Island

	Kent County Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Landmark Medical Center	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Memorial Hospital of RI	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Miriam Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Newport Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Rhode Island Hospital – including Hasbro Children's Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Roger Williams Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	St. Joseph's Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)
	Women and Infants Hospital	$300 (NL*)	$300 (NL*)	$300 (NL*)

NL* These *Hospitals* are not grouped in a *Copayment*/*Coinsurance* level because they: (1) are a specialized hospital, (2) have fewer than 100 admissions per year for pediatrics or obstetrics, (3) do not provide pediatric or obstetric services, or (4) are a *Network Hospital* outside of Massachusetts. *Members* are encouraged to contact their treating *Provider* or the *Hospital* directly if they have questions about the services available at a specific *Hospital*.

Please note that the status and *Copayment* levels of our network of *Providers* are in effect as of July 1, 2005. For the most up-to-date status, please contact *Member Services* at 1-800-870-9488.

Benefit Clarifications:

•Family planning procedures, services, and contraceptives

- For purposes of clarification, coverage at the *In-Network Level of Benefits* for "Family planning procedures, services, and contraceptives" (listed in the "Benefit Overview" section on page 11 in your 2004 Navigator *Member Handbook*) is changed to read as follows to list the *Member's* Cost for *Day Surgery*:

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Family planning procedures, services, and contraceptives ☞ Page 36	Office Visit*: $15 *Copayment* *Day Surgery**: $75 *Copayment* per person per *Day Surgery* admission, up to the *Day Surgery Copayment* Maximum described on page 10 above. ***Note**: Depending on the type of service received, you will pay either an office visit or Day Surgery Copayment.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

•Diagnostic x-rays and lab services

For purposes of clarification, the "Diagnostic x-rays and laboratory services" benefit under "*Outpatient* medical care" in your 2004 Navigator *Member Handbook* has been replaced with separate new benefits for "Diagnostic tests and laboratory services" and "Diagnostic imaging." As a result of this change:

- the "Diagnostic x-rays and lab services" benefit listed on page 12 in the "Benefit Overview" section is replaced with the following two benefits:

Covered Services	**In-Network**	**Out-of-Network**
	***Member's* Cost**	***Member's* Cost**
Diagnostic tests and laboratory services **(AR)** ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)
Diagnostic imaging • General imaging (such as x-rays and ultrasounds) • MRI/MRA, CT/CTA, PET and nuclear medicine ☞ Page 38	Covered in full.	*Deductible* & 20% of the *Reasonable Charge* (plus any balance)

- the "Diagnostic x-rays and lab services" benefit listed on page 38 in the "Covered Services" section is replaced with the following two benefits:
  - Diagnostic tests and laboratory services, including, but not limited to, glycosolated hemoglobin (A1c) tests and urinary protein/microalbumin and lipid profiles. Some diagnostic tests (e.g., genetic testing) may require the approval of an *Authorized Reviewer*. This approval is required at both the *In-Network* and *Out-of-Network Levels of Benefits*. See "Important Notes" on page 34 for more information about when you are responsible for obtaining this approval.
  - Diagnostic imaging, including general imaging (such as x-rays and ultrasounds) and MRI/MRA, CT/CTA, and PET tests and nuclear medicine.

- ***Emergency* Care *Copayment***

The "Notes" section in the "*Emergency* Care" benefit description on page 35 (see Part 5, "*Covered Services,*" in your 2004 Navigator *Member Handbook*) is changed to read as follows:

Notes:

- The *Emergency* Room *Copayment* is waived if the *Emergency* room visit results in an immediate hospitalization. The applicable *Inpatient Copayment* will apply for that hospital admission.
- The *Emergency* Room *Copayment* is waived if the *Emergency* room visit results in an immediate *Day Surgery*. The *Day Surgery Copayment* may apply if *Day Surgery* services are received. If you are admitted to the hospital immediately following that *Day Surgery*, the *Day Surgery Copayment* will be waived and you will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission.
- *Emergency Covered Services* received from a non-*Tufts HP Provider* are subject to the *Emergency* Room *Copayment*. Then, those services are covered in full. In the event that you receive a bill for these services from a non-Tufts HP *Provider*, please contact the Member Services Department at 1-800-870-9488.

- ***Day Surgery Copayment***

Also, the following "Note" is added to the "*Day Surgery*" benefit description on page 40 (see Part 5, "*Covered Services,*" in your 2004 Navigator *Member Handbook*):

Note: If you are admitted to that *Tufts HP Hospital* immediately following *Day Surgery*, the *Day Surgery Copayment* will be waived. You will instead be required to pay the applicable *Inpatient Copayment* for that hospital admission.

- **Benefits requiring *Authorized Reviewer* approval**

For purposes of clarification, the following benefits listed in your 2004 Navigator *Member Handbook* are changed to require review and approval by an *Authorized Reviewer* in order to be considered *Covered Services*:

- Certain ambulance services (see "Ambulance services" on page 16 in your 2004 Navigator *Member Handbook*. Also, see "Ambulance services" on page 43 in your 2004 Navigator *Member Handbook* to determine which services require Authorized Review);
- Certain diagnostic tests and laboratory services (see "*Outpatient* medical care" on pages 12 of your 2004 Navigator *Member Handbook*. Also see page 38 of your 2004 Navigator *Member Handbook* and page 8 of this *Benefit Update* to determine which services require Authorized Review);
- Extended care services (see "Extended Care" on pages 16 and 43 of your 2004 Navigator *Member Handbook*);
- Inpatient surgery (see "Acute hospital services" on pages 15 and 41 of your 2004 Navigator *Member Handbook*);
- Non-prescription enteral formulas and special medical formulas (see "Special medical formulas" on pages 17 and 47 of your 2004 Navigator *Member Handbook*);
- Prosthetic Devices (see "Durable Medical Equipment" on pages 16 and 45 of your 2004 Navigator *Member Handbook*. Please note that approval by an *Authorized Reviewer* is not required for breast prostheses in connection with a mastectomy.)

As a result of this change, an "**(AR)**" symbol is added to the "*Covered Services*" column next to each of these benefits listed in the "Benefit Overview" section (Part 1). This symbol is used to indicate the services that may require approval by an *Authorized Reviewer* prior to treatment for coverage at both the *In-Network and Out-of-Network Levels of Benefits*.

In addition, for each of the benefits listed above, the following note is added to the description of that benefit in the "Covered Services" section (Part 5) of your 2004 Navigator *Member Handbook*:

Prior approval by an *Authorized Reviewer* is required at both the *In-Network and Out-of-Network Levels of Benefits*. See "Important Notes" on page 34 of your 2004 Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

•Infertility services

For purposes of clarification, the benefit description for infertility services in the "Covered Services" section (see Part 5, page 37 in your 2004 Navigator *Member Handbook*) is changed to read as follows:

Diagnosis and treatment of Infertility* in accordance with Massachusetts law.

Note: Oral and injectable drug therapies used in the treatment of infertility associated with the *Covered Services* below are considered *Covered Services* only when the *Member* has been approved for associated infertility services. See your Prescription Drug Benefit section for your *Copayment* amounts.

Infertility services include:

(I.) the following services and supplies provided in connection with an infertility evaluation when approved in advance by an *Authorized Reviewer* (see "Important Notes" on page 34 in your 2004 Navigator *Member Handbook* for more information):
- diagnostic procedures and tests;
- artificial insemination (intrauterine or intracervical) when done with non-donor (partner) sperm; and
- procurement, processing, and long-term (longer than 90 days) banking of sperm when associated with active infertility treatment.

(II.) the following procedures when approved in advance by an *Authorized Reviewer* (see "Important Notes" on page 34 in your 2004 Navigator *Member Handbook* for more information):
- artificial insemination (intrauterine or intracervical) when done with donor sperm; and
- procurement and processing of eggs or inseminated eggs or banking of inseminated eggs when associated with active infertility treatment.

Note: Donor sperm is only covered when the partner has a diagnosis of male factor infertility.

(III.) the following Assisted Reproductive Technology ("ART") procedures when approved in advance by an *Authorized Reviewer* **:
- I.V.F. (in-vitro fertilization and embryo transfer);
- D.O. (donor oocyte);
- F.E.T. (frozen embryo transfer);
- Z.I.F.T. (zygote intra-fallopian transfer);
- G.I.F.T. (gamete intra-fallopian transfer); and
- I.C.S.I. (intracytoplasmic sperm injection).

**Note: These ART procedures will only be considered *Covered Services* for *Members* with Infertility:
- who meet *Tufts HP's* eligibility requirements, which are based on the *Member's* medical history;
- who meet the eligibility requirements of *Tufts HP's* contracting Infertility Services providers;
- when approved in advance by an *Authorized Reviewer* at both the *In-Network* and *Out-of-Network Levels of Benefits* (see "Important Note" on page 34 in your 2004 Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval); and
- with respect to the procurement and processing of donor sperm, eggs, or inseminated eggs, or the banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's health care coverage, if any.

Coverage for Assisted Reproductive Technology (ART) is provided only when *Medically Necessary* and is subject to approval in advance by an *Authorized Reviewer* at both the In-Network and Out-of-Network Levels of Benefits (see "Important Notes" on page 34 in your 2004 Navigator *Member Handbook* of Part 5 for more information about when you are responsible for obtaining this approval). ART services are provided up to a maximum of 5 attempts. Exceptions will be made only when *Tufts Health Plan* determines the services to be *Medically Necessary*.

*Infertility is defined as the condition of a presumably healthy Member who has been unable to conceive or produce conception during a period of one year.

•Allergy injections

For purposes of clarification, the "Allergy testing (including antigens) and treatment" benefit in "Outpatient medical care" on page 38 of the "Covered Services" section in your 2004 Navigator *Member Handbook* is changed to read as follows:

Allergy testing and treatment

Allergy testing (including antigens) and treatment, and allergy injections.

•Patient care services provided as part of a qualified clinical trial

For purposes of clarification, the title for this benefit (in Part 5 in your 2004 Navigator *Member Handbook*, under both "Outpatient Care" on page 39 and "Inpatient Care" on page 42) is changed to read "Patient care services provided as part of a qualified clinical trial for the treatment of cancer."

•Reconstructive surgery and procedures

This benefit (see page 42 in your 2004 Navigator *Member Handbook*) is clarified with respect to the surgery and procedures subject to prior approval by an *Authorized Reviewer*. As a result of this clarification, the second bulleted item in the "Notes" section of this benefit has been changed to read as follows:

- Except as described above in connection with a mastectomy, *Authorized Reviewer* approval is required before you receive any reconstructive surgery or procedure. This prior approval by an *Authorized Reviewer* is required at both the In-Network and Out-of-Network Levels of Benefits. See "Important Notes" on page 34 in your 2004 Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

•Ambulance services

For purposes of clarification, the benefit description for ambulance services in the "Covered Services" section (see Part 5, page 43 in your 2004 Navigator *Member Handbook*) is changed to read as follows:

- Ground, sea, and helicopter ambulance transportation for *Emergency* care.
- Airplane ambulance services (e.g., Medflight) when approved by an *Authorized Reviewer**.
- Non-emergency, *Medically Necessary* ambulance transportation between covered facilities.
- Non-emergency ambulance transportation for *Medically Necessary* care when the medical condition of the *Member* prevents safe transportation by any other means. Prior approval by an *Authorized Reviewer* is required*.

*Prior approval by an Authorized Reviewer is required for these benefits at both the In-Network and Out-of-Network Levels of Benefits. Please see "Important Notes" on page 34 in your 2004 Navigator *Member Handbook* for more information about when you are responsible for obtaining this approval.

•Durable Medical Equipment

For purposes of clarification, the following item is added to "Examples of excluded items" section in the "Durable Medical Equipment" benefit (see Part 5, page 45 in your 2004 Navigator *Member Handbook*):

- any type of thermal therapy device.

•Prescription Drug Benefit

For purposes of clarification, the bulleted item describing coverage for "oral contraceptives, diaphragms, and Depo-Provera" under the "What is Covered" section (see Part 5, page 49 in your 2004 Navigator *Member Handbook*) is changed to read as follows:

- Oral contraceptives, diaphragms, Depo-Provera, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law*.

  *Note: This Prescription Drug Benefit only describes contraceptive coverage for oral contraceptives, diaphragms, Depo-Provera, and other hormonal contraceptives (e.g., patches, rings) that require a prescription by law. See "Family planning" on page 36 in your 2004 Navigator *Member Handbook* for information about other contraceptive drugs and devices that qualify as *Covered Services*. Also note that, in certain circumstances, Depo-Provera may qualify as a *Covered Service* under the "Family planning" benefit.

•Exclusions from Benefits

For purposes of clarification, the following changes have been made to the "Exclusions from Benefits" section (see Part 5, pages 53-55 in your 2004 Navigator *Member Handbook*):

- The following items are added:
  - Treatment of vitiligo.
  - Exercise classes.
  - Any type of thermal therapy device.
- The exclusion from benefits related to infertility services now includes the following "Note":

  Note: *Tufts HP* may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a *Member's* future fertility. Prior approval by an *Authorized Reviewer* is required.
- The following sentence has been added to the exclusion related to examinations, evaluations, or services for educational or developmental purposes:

  The term "developmental" refers to a delay in the expected achievement of age-appropriate fine motor, gross motor, social, or language milestones that is not caused by an underlying medical illness or condition.

Changes to Other Provisions:

· Your HIPAA Portability Rights

The following section, captioned "Your HIPAA Portability Rights" has been added to the "When Coverage Ends" section (Part 4, page 33 in your 2004 Navigator *Member Handbook*):

•Your HIPAA Portability Rights

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance (617-521-7777) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

Using Certificates of Creditable Coverage to reduce pre-existing condition exclusion waiting periods. *Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as 'pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.*

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior 'creditable' coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare, and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage).

(continued on next page)

When you have the right to specially enroll in another plan. If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, should you have such a life event or your coverage end, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You have the right not to be discriminated against based on health status. A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When you have the right to individual coverage. If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (shown on this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premium;
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

•Nongroup Coverage

The first paragraph of "Effective Date of *Nongroup Coverage* and Waiting Period" (see Part 6, page 59 in your 2004 Navigator *Member Handbook* has been revised to clarify that a *Member's Effective Date* will not appear on his or her member ID for Nongroup Coverage.

•Member Appeals Process

The "Member Appeals Process" section (see Part 7, "Member Satisfaction", on pages 60-62 in your 2004 Navigator *Member Handbook*) has been revised to read as follows:

Tufts Health Plan ("*Tufts HP*") has a Member Satisfaction Process to address your concerns promptly. This process addresses:

- Internal Inquiry;
- Member Grievance Process; and
- Appeals:
  - Internal Member Appeals, and
  - Expedited Appeals.

All grievances and appeals should be sent to *Tufts HP* at the following address:

Tufts Health Plan
Navigator Plan
Attn: Appeals and Grievances Department
705 Mt. Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

All calls should be directed to the Member Services Department at **1-800-870-9488**.

Internal Inquiry

Call the Member Services Department to discuss concerns you may have regarding your health care. Every effort will be made to resolve your concerns. If your concerns cannot be explained or resolved, or if you tell a Member Services Coordinator that you are not satisfied with the response you have received from *Tufts HP*, we will notify you of any options you may have, including the right to have your inquiry processed as a grievance or appeal. If you choose to file a grievance or appeal, you will receive written acknowledgement and written resolution in accordance with the timelines outlined below.

(continued on next page)

•Member Appeals Process - continued

Grievances

A grievance is a formal complaint about actions taken by *Tufts HP* or a *Provider*. There are two types of grievances: administrative grievances and clinical grievances. The two types of grievances are described below.

It is important that you contact *Tufts HP* as soon as possible to explain your concern. Call a *Tufts HP* Member Services Coordinator, who will document your concern and forward it to a Grievance Analyst in the Appeals and Grievances Department. Grievances may be filed either verbally or in writing. To accurately reflect your concerns, you may want to put your grievance in writing and send it to the address provided at the beginning of this section. Your explanation should include:

- your name and address;
- your Member ID number;
- a detailed description of your concern (including relevant dates, any applicable medical information, and *Provider* names); and
- any supporting documentation.

Important Note: The *Member* Grievance Process does not apply to requests for a review of a denial of coverage. If you are seeking such a review, please see the "Internal *Member* Appeals" section below.

Administrative Grievances

An administrative grievance is a complaint about a *Tufts HP* employee, department, policy, or procedure, or about a billing issue.

Administrative Grievance Timeline

- If you file your grievance in writing, *Tufts HP* will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance.
- If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.
- *Tufts HP* will review your grievance and will send you a letter regarding the outcome within thirty (30) calendar days of receipt.
- The time limits in this process may be waived or extended upon mutual written agreement between you or your authorized representative and *Tufts HP*.

Clinical Grievances

A clinical grievance is a complaint about the quality of care or services that you have received. If you have concerns about your medical care, you should discuss them directly with your *Provider*. If you are not satisfied with your *Provider's* response or do not wish to address your concerns directly with your *Provider*, you may contact Member Services to file a clinical grievance.

If you file your grievance in writing, we will notify you by mail, within five (5) business days after receiving your letter, that your letter has been received and provide you with the name, address, and telephone number of the Grievance Analyst coordinating the review of your grievance. If you file your grievance verbally, we will send you a written confirmation of our understanding of your concerns within forty-eight (48) hours. We will also include the name, address, and telephone number of the person coordinating the review.

Tufts HP will review your grievance and will notify you in writing regarding the outcome, as allowed by law, within thirty (30) calendar days of receipt. The review period may be extended up to an additional thirty (30) days if additional time is needed to complete the review of your concern. You will be notified in writing if the review timeframe is extended.

Internal Member Appeals

Requests for coverage that was denied as specifically excluded in your 2004 Navigator *Member Handbook* (or subsequent updates) or for coverage that was denied based on medical necessity determinations are reviewed as appeals through *Tufts Health Plan's* Internal Appeals Process. You may file a request yourself or you may designate someone to act on your behalf in writing. You have 180 days from the date you were notified of the denial of benefit coverage or claim payment to file your appeal.

(continued on next page)

•Member Appeals Process - continued

Internal Member Appeals - continued

(i) You can submit a verbal appeal of a benefit coverage decision to the Member Services Department, who will forward it to the Appeals and Grievances Department. You can also submit a written appeal to the address listed above under "Grievances." *Tufts HP* encourages you to submit your appeal in writing to accurately reflect your concerns. Your letter should include:

- your complete name and address;
- your ID number;
- a detailed description of your concern; and
- copies of any supporting documentation.

(ii) Within five (5) business days following *Tufts Health Plan's* receipt of your written appeal, a *Tufts Health Plan* Appeals Analyst will send you an acknowledgment letter and, if appropriate, a request for authorization for the release of your medical and treatment information related to your appeal. Within 48 hours of receipt of a verbal appeal, a *Tufts Health Plan* Appeals Analyst will summarize your request for an appeal and send a copy to you. This summary will serve as the acknowledgment of receipt of your appeal and if appropriate, will include a request for authorization for the release of related medical and treatment information.

Once you have signed and returned the authorization for the release of medical and treatment information to *Tufts Health Plan*, an Appeals Analyst will document the date of receipt and coordinate the investigation of your appeal. In the event that you do not sign and return the authorization for the release of medical and treatment information to *Tufts Health Plan* within thirty (30) calendar days of the day you requested a review of your case, *Tufts HP* may, in its discretion, issue a resolution of the appeal without reviewing some or all of your medical records.

(iii) The *Tufts Health Plan* Benefits Committee will review appeals concerning specific exclusions and make determinations. The *Tufts Health Plan* Appeals Committee will make utilization management (medical necessity) decisions. If your appeal involves an adverse determination (medical necessity determination), it will be reviewed by a medical director and/or a practitioner in the same or in a similar specialty that typically manages the medical condition, procedure, or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

If the case involves an adverse determination (medical necessity determination) and you would like to address the Committee, you should contact the Appeals Analyst who is handling your appeal. If you ask to attend the meeting, *Tufts HP* will notify you of the date and time. You will have access to any medical information and records relevant to your appeal which are in the possession and control of *Tufts HP*. The time limits of this process will be waived or extended by a mutual written agreement between you or your authorized representative and *Tufts HP*.

(iv) The Appeals Analyst will notify you in writing of the Committee's decision within no more than thirty (30) calendar days of the receipt of your appeal. A copy of the decision will be sent to your physician, except in the case of Mental Health Appeals or if you request otherwise. A determination of claim denial will set forth:

- *Tufts Health Plan's* understanding of the request;
- the reason(s) for the denial;
- a specific reference to the contract provisions on which the denial is based; and
- the clinical rationale for the denial.

The determination of claim denial will also direct the *Member* to the Executive Director of the *GIC* for final appeal review and determination. Claim denials based upon the *Plan's* determination that the service is specifically excluded from coverage in the 2004 Navigator *Member Handbook* (or subsequent updates) are not appealable to the *GIC*.

Tufts Health Plan maintains records of each inquiry made by a *Member* or by that *Member's* designated representative.

•Member Appeals Process - continued

Expedited Appeals

You may request an expedited appeal in situations when your health or well-being is at risk, or when coverage for your *Inpatient* care has been denied, by calling the Member Services Department. If your request does not meet the guidelines for an expedited appeal, *Tufts HP* will explain your right to use the standard appeals process.

If your request meets the guidelines for an expedited appeal, it will be reviewed by a medical director and/or practitioner in the same or in a similar specialty that typically manages the medical condition, procedure or treatment under review. The medical director and/or practitioner will not have previously reviewed your case.

Tufts HP will notify you by telephone within one business day after receiving the information necessary to conduct your appeal, but no later than 72 hours after *Tufts Health Plan's* receipt of the request.

If You Have Questions

If you have questions or need help submitting a grievance or an appeal, please call the Member Services Department for assistance.

•Subrogation

For purposes of clarification, the "Subrogation" provision (see Part 8, page 63 in your 2004 Navigator *Member Handbook*) has been changed as follows:

- Under "The *Plan's* right of subrogation" provision, the reference to "a workers' compensation insurer" has been removed.
- The following new "Workers' Compensation" provision is added:

  Workers' compensation

  Employers provide workers' compensation insurance for their employees to protect them in case of work-related illness or injury.

  If you have a work-related illness or injury, you and your employer must ensure that all medical claims related to the illness or injury are billed to your employer's workers' compensation insurer. The *Plan* will not provide coverage for any injury or illness for which it determines that benefits are available under any workers' compensation coverage or equivalent employer liability, or indemnification law.

  If the *Plan* pays for the costs of health care services or medications for any work-related illness or injury, the *Plan* has the right to recover those costs from you, the person, or company legally obligated to pay for such services, or from the *Provider*. If your *Provider* bills services or medications to the *Plan* for any work-related illness or injury, please contact the Member Services Department.
- Under "The *Plan's* right of reimbursement" provision, the reference to "health care services and supplies" has been changed to read as "health care services, medications, and supplies."

· Terms and Definitions

The following changes have been made to the "Terms and Definitions" section (Part 9, pages 66-72 in your 2004 Navigator *Member Handbook*):

- The "Note" in the "*Covered Services*" definition on page 67 has been changed to read as follows:

  Note: Covered Services include any surcharges on the plan such as the Massachusetts Uncompensated Care Pool or New York Health Care Reform Act surcharges, or later billed charges under provider network agreements, such as supplemental provider payments or access fee arrangements.

The reference to "applicable state law" in the "*Provider*" definition on page 71 has been changed to read as "applicable law."

Need to Write or Call?

Tufts Health Plan
705 Mt. Auburn Street, P.O. Box 9173
Watertown, MA 02471-9173

1-800-870-9488

For the Enrollee Assistance Program or
Mental Health or Substance Abuse treatment,
please call United Behavioral Health

1-888-610-9039

Commonwealth of Massachusetts
Group Insurance Commission

NAVIGATOR
by TUFTS Health Plan

Tufts Health Plan
333 Wyman Street, P.O. Box 9112
Waltham, MA 02454-9112

For additional information,
please call 1-800-870-9488

www.tuftshealthplan.com

Offered by Tufts Benefit Administrators, Inc.
Tufts Health Plan reserves the right to add to, change, or withdraw the services described in this booklet at any time.

GIC-NAVPPO-AMDMT-001 Ed. 7-2005